ADULT PATIENT INFORMATION **Today's Date** _____

Please print

Name:_____ **Birthday:**_____ **Sex:** M F

Address:_____**City:**_____**State:**_____**ZIP:**_____

Home Phone (_____)_____ **Cell** (_____)_____

Work phone:_____ **Referred to this office by:** _____

E-mail Address:_____

Do you have Medicare? ❑ Yes (accepted) ❑ No

Date of your last eye examination_____ **Have you ever had vision therapy?** ❑ Yes ❑ No

Have you ever worn glasses? ❑Yes ❑No **Do you wear glasses now?** ❑ Yes ❑No

If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports

Do you have a specific vision concern to discuss today? _____

_____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies	❑Self	❑ Family	Lazy eye	❑ Self	❑ Family
Respiratory disease	❑Self	❑ Family	Turned eye	❑ Self	❑ Family
Cancer	❑Self	❑ Family	Color "blind"	❑ Self	❑ Family
Diabetes	❑Self	❑ Family	Light sensitive	❑ Self	❑ Family
Drug sensitive	❑Self	❑ Family	Eyestrain	❑ Self	❑ Family
Elevated cholesterol	❑Self	❑ Family	Dry eyes	❑ Self	❑ Family
Heart problem	❑Self	❑ Family	Floaters/spots	❑ Self	❑ Family
High blood pressure	❑Self	❑ Family	Flashing lights	❑ Self	❑ Family
Thyroid	❑Self	❑ Family	Retinal detachment	❑ Self	❑ Family
Migraine or headaches	❑Self	❑ Family	Blindness	❑ Self	❑ Family
Head trauma	❑Self		Cataracts	❑ Self	❑ Family
			Glaucoma	❑ Self	❑ Family
			Eye surgery or injury	_____	

Are you currently under a physician's care? ❑No ❑ Yes **Dr.'s name:** _____

Are you regularly taking medications? ❑No ❑ Yes **Date of last physical** _____

List medication(s) currently taking: _____

How is your general health? (circle one) Excellent Good Fair Poor

Do you wear contact lenses at this time? ❑Yes ❑No What type? _____

Have you had problems wearing contacts? ❑Yes ❑No Describe _____

Have you been told you cannot wear them? ❑Yes ❑No Are you interested in trying contacts? ❑Yes ❑No

PAYMENT TERMS: Office policy calls for payment at the time of service or when ordering eyewear/ contact lenses, We accept cash, personal checks, Visa, MasterCard, and Discover. I have read and agree to all the provisions of the office financial policy

Signed _____ Date _____

PATIENT SYMPTOM CHECKLIST

PATIENT NAME: _____ DATE: _____

Please check all symptoms that apply:

___ Headaches, dizziness, nausea

___ Eye pain

___ Double vision

___ Slow, difficult time reading

___ Avoidance of reading/near work

___ Blurry vision

___ Light sensitivity

___ Sound sensitivity

___ Skips lines of text when reading

___ Words “move on the page”

___ Closing/blocking one eye to read

___ Red, sore, itchy eyes

___ Omits, inserts/re-reads letters/words

___ Fatigue, frustration w/ reading/homework

___ Failure to recognize same word in next line

___ Confuses similar looking words

___ One eye turns in or out

___ Letters/word reversals after 1st grade

___ Behind grade level in reading

___ Frequent loss of place while reading

___ Poor hand writing, Misaligns numbers

___ Poor reading comprehension

___ Object appear to grow larger or smaller

___ Poor balance

___ Short attention span

___ ADD, ADHD, LD or Dyslexic

Cantwell Vision Therapy Centers

7002-B Little River Turnpike
Annandale, VA 22003
(703) 941-3937

44075 Pipeline Plaza #100
Ashburn, VA 20147
(703) 729-3545

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that a copy of the ***Notice of Privacy Practices*** for Cantwell Vision Therapy Centers, Dr. Dennis R. Cantwell, O.D., has been made available for viewing. (A copy will be given upon request – see receptionist).

Patient Name: (print) _____

Signature: _____
(patient or parent / guardian if patient is a minor)

Date: _____

Do you want your information to be made available to: (***without your written request***)

Other eye care professionals yes _____ no _____
(This is if you need a prescription or a
Copy of your records faxed at your request.)

Family members yes _____ no _____

Your insurance company yes _____ no _____